

Mental Welfare Commission for Scotland

Report on an unannounced visit to: Western Isles Hospital,
Clisham Ward, MacAulay Road, Stornoway, Isle of Lewis HS1
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Date of visit. 6 March 2017

Where we visited

Clisham ward is a 10-bedded ward (with two contingency beds) for older adults with a focus on dementia care. The ward is situated within a general hospital setting.

We last visited the service on 29 November 2016. On the day of our visit we wanted to follow up on the previous recommendations about ensuring that life story work is fully completed; improving discharge planning systems in conjunction with social work; ensuring activity plans are person-centred; and resolving issues with storage of clothing in bed areas.

We also wanted to look at care plans, how activities were being recorded and at the personalisation of the environment.

Who we met with

We met with and reviewed the care and treatment of six patients.

We met with two family members.

We spoke with the Clisham ward staff nurse on the day, as well as other nursing staff. We also met with the associate director of mental health & learning disabilities, and the senior charge nurse for mental health inpatient services.

Commission visitors

Mary Leroy, Nursing Officer (visit co-ordinator)

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

There was a calm atmosphere in the ward. All the interactions towards patients we observed from staff were friendly and supportive. Staff were knowledgeable about the patients when we discussed their care. We heard positive comments about staff from some patients we met. We reviewed the patients' care plans; many were person-centred containing individualised information, and they identified clear interventions and care goals. However, there were also some standardised care plans that were not person-centred and did not reflect the specific care needs of the individual.

Recommendation 1:

Managers should ensure that all care plans are person-centred, containing individualised information, reflecting the care needs of each person and identifying clear interventions and care goals.

Where it was deemed necessary to use covert medication, the Commission's pathway was in place. However, the final section of the pathway, which asks for a plan to outline the method of covert administration for each medication, was not completed. This section needs to be completed through discussion with the pharmacist, and details the method of how the medication should be administered to the patient. Furthermore, we did not find Adults with Incapacity (Scotland) Act 2000 ('AWIA') s47 consent to treatment forms or accompanying treatment plans in place for some of those patients.

Recommendation 2:

Managers should ensure that when a patient is in receipt of covert medication, this is included on the s47 certificate and that a copy of the s47 certificate, treatment plan and covert medication pathway are stored with the drug prescription sheet.

We discussed discharge planning with the staff team. Currently the social work and health partnership staff are undertaking assessments of all patients and looking for potential placements that will meet their individual needs. During this discussion, we heard that the NHS Board and Integration Joint Board (IJB) are working with services to redesign how they provide mental health care to the people of the Western Isles. The consultation period had generated four potential options. These options have been reviewed and assessed against a set of criteria. Following this process, the preferred choice was for 'a community focussed service model' with facility for short-term (crisis/short term detention) local beds staffed by the community mental health team.

Multidisciplinary team (MDT) input

We saw good risk assessments, undertaken by staff on admission, which were regularly reviewed. We were pleased to hear that the service is developing the Newcastle model of care; this is an enhanced model of support for people with dementia who experience stress and distress. We were informed that one of the nurses had attended training in the Newcastle model and there were plans for multidisciplinary work with psychology to embed this model into practice.

The MDT review meeting is held weekly and is attended by nursing staff and the consultant psychiatrist. Other staff, for example social workers or community psychiatric nurses (CPNs) only attend if required. The family members we met with on the day commented that the MDT team communicated regularly with them, updating them with changes to their family member's care, when appropriate. Families commented that they were frequently invited to attend the MDT.

Engagement with carers and relatives

The charge nurse told us that families/carers can phone nursing staff for updates at any time. They are also informed that they can make individual appointments with the

consultant psychiatrist. We met with two families, who both commented on feeling involved in their relative's care as appropriate. The families felt that all issues relating to care were discussed, and, although conversations could be difficult at times, the families felt listened to. The two families we met with felt that the flexibility with visiting time was helpful for both patients and families, some of whom travelled long distances to be there.

Mental health and incapacity legislation

We examined drug prescription sheets and Mental Health (Care & Treatment) (Scotland) Act 2003 'consent to treatment (T2)' and 'certificate authorising treatment (T3)' certificates. All were in place for all patients who required them. Mental health act paperwork and copies of all relevant documentation were also available within the patient file as appropriate.

AWIA welfare guardianship, power of attorney and s47 treatment certificates were in place. There was clear evidence of contact with guardians and attorneys at appropriate times.

In Clisham ward, the 'do not attempt cardiopulmonary resuscitation' (DNACPR) paperwork highlighted that appropriate discussions had been held and recorded with relatives. However, we did find that the most up to date copy was not on file in the nursing notes.

Recommendation 3:

The ward manager should audit patients' notes to ensure the most recent DNACPR form is held on file.

Activity and occupation

There is very little regular occupational therapy input into Clisham ward although there is access on a referral basis. Two healthcare assistants provide a range of activities but these are not routinely planned into a daily programme. Most of the activities available to the patients are delivered in one-to-one sessions. Patients can access an activity room which has facilities for art and games. On reviewing the patients' notes, the service appears to be operating two methods of record keeping for activities. We discussed with the staff and service manager that there was a need for them to ensure there is one system used to document the patients' daily activities and that this system is reviewed and audited on a regular basis.

Recommendation 4:

Managers should review how activities are provided and ensure there is a system in place that allows this information to be recorded consistently into the patient's notes.

The physical environment

Clisham ward had recently been refurbished and dementia friendly signage was in place, but this could be extended to the use of personal pictures and photos on doors to help the patients recognise their bedrooms. The staff have laminated some photos and images with relevance to individual patients to personalise the patient's bedroom spaces. There are plans in place to improve the garden space to make it more dementia friendly in line with the Stirling Dementia Services Development centre guidance.

Summary of recommendations

1. Managers must ensure that all care plans are person centred, containing individualised information, reflecting the care needs of each person and identifying clear interventions and care goals.
2. When a patient is in receipt of covert medication we recommend that this is included on the s47 certificate and that a copy of the s47 certificate, treatment plan and covert medication pathway be stored with the drug prescription sheet.
3. The ward manager should audit the patient's notes to ensure the most recent DNACPR form is held on file.
4. Managers should review how activities are provided and ensure there is a system in place that allows this information to be recorded consistently into the patient's notes.

A copy of this report will be sent for information to Healthcare Improvement Scotland

Kate Fearnley

Executive Director (engagement and participation)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors. Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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